Smoke-free policies in psychiatric hospitals might reduce staff risk of violence, but they need adequate resources for their implementation

How should institutions where patients can be held without their consent implement a smoke-free policy? Smoking is seen at far higher rates in populations with mental health problems than the general population, and as a result, people with these illnesses have on average 12-15 years reduced life expectancy than the general population, being more likely to suffer from smoking-related ill health (1). Despite this, many have argued that encouraging smoking cessation should not be a priority for those with severe mental health problems, and indeed could even detract from treatment for their conditions.

The evidence fails to support these claims. Not only has smoking cessation not been shown to have a negative impact on mental health (2), but when questioned, patients in psychiatric hospitals report being just as keen to quit smoking as the general population. So why is there still resistance to the introduction of smoke-free policies in psychiatric hospitals?

One plausible explanation is the perception of staff working in psychiatric hospitals that they will be at risk of increased violence if they have to withhold cigarettes from smokers (3). Staff in these hospitals are often subject to violence from patients, so their fear is understandable. The recent paper by Robson et al (4) may go some way to assuage those fears. Across four psychiatric hospitals in South London, the authors found that physical violence both between patients and towards staff declined after a smoke-free policy was introduced. Although not a randomized trial, this was the first study to robustly assess the association using an interrupted time series design, taking measures before and after the introduction of the smoke-free policy, and controlling for potential confounders including time and seasonality.

The smoke-free policy introduced at the hospitals in the study included staff training and tobacco dependence treatment, and allowed the use of e-cigarettes by patients. The authors suggest that the provision of adequate support to alleviate the symptoms of nicotine withdrawal, which are easily confused with worsening mental health, could be the reason for the drop in violence after the smoke-free policy was introduced.

These provisions are in line with NICE guidelines, which recommend that smoke-free NHS sites provide comprehensive on-site stop smoking services, including trained staff who can identify people who smoke and who are able to offer behavioural and pharmacological support in a timely manner. These guidelines are evidence based, with a systematic review of smoke-free psychiatric hospitals finding that those hospitals with comprehensive smoking bans alongside adequate smoking cessation support were more effective at encouraging smoking cessation than those with partial bans (5).

The current study did not look at verbal abuse rates, and did not measure adherence to the smoke-free policy, both of which would have been informative measures. Qualitative work alongside a study such as this would be enlightening

as to the experience of patients and staff implementing this policy. Similarly, longer term follow up will allow investigation of the effectiveness of the smoke-free policy in terms of aiding lasting quit attempts for patients, and preventing smoking related harm in these populations.

This study has important implications for the introduction of smoke-free policies in other institutions where individuals are incarcerated against their will, such as prisons, where fears of increased violence might also discourage their implementation. Research on smoking bans in prisons has found some evidence that prisoners' second-hand smoke exposure decreases after partial smoking bans. Partial bans have also been shown to result in lower smoking related mortality, with some evidence that this is particularly the case for those with a diagnosed mental illness (6). Despite this, partial smoking bans in prisons have not been found to lead to a reduction in active smoking rates (6). The US Supreme Court has described prisoners' exposure to second-hand smoke as a 'cruel and unusual punishment' (7) and more research on smoking bans in prison populations is needed, as is research investigating the incidence of violence after the introduction of these policies.

We are currently lacking good quality evidence on the most effective methods to enact smoke-free policies in settings with incarcerated populations, and in particular how to aid smoking cessation in populations with severe mental health problems. Research on the impact of smoking cessation on mental health conditions should also be a priority. Crucially, Robson et al's study highlights the vital importance of adequate funding, training and support for staff in these institutions to allow them to effectively implement such policies. Patients with severe mental health problems should not be abandoned to their increased risk of smoking related death and disease. With compassion and support such individuals can be helped to stop smoking.

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